ECLC of NJ 973-635-1700 **EMERGENCY REFERENCE CARD** **BUS________HR________**

Student ____ Birth date ____

Street Address______________________ Town/Zip___________________________ ***Check if new address*** ________________

Phone

Mother/Guardian____________________ Address____________________________ _______________________________ (H)

___________________________________ _______________________________ (C)

Email ____ _______________________________ (W)

Father/Guardian_____________________ Address____________________________ _______________________________ (H)

___________________________________ _______________________________ (C)

Email ____ _______________________________ (W)

LOCAL person to be called if parent/guardian not available in case of emergency:

Phone

Name______________________________ Town_____________________________ _________________________________(H)

Relationship________________________ _________________________________(C)

Name______________________________ Town_____________________________ _________________________________(H)

Relationship________________________ _________________________________(C)

Technology Survey:

In the event of a school closure, do you have access to the internet at home? Yes _________________ No ___________________

Do you have a smart device at home (computer, laptop, tablet, smartphone)? Yes _________________ No ___________________

Student's Physician______________________________________ Phone ____

Preferred hospital for emergency____

Does student take daily medication?_______________________ Medication/Dose______________________________________

Medication/Dose______________________________________

Medication/Dose______________________________________

Does student have emergency medication?_________________ Medication/Dose______________________________________

Does student have allergies?____________________________ Reaction/Treatment___________________________________

Does student have health insurance?

Yes______________________ Name of insurance provider____

No_______________________ NJ Family Care provides free and low-cost medical insurance for uninsured children and certain low-income families. For information call 800-701-0710 or visit www.njfamilycare.org to apply on line.

ECLC of NJ may release my name and address to NJ Family Care to contact me about health insurance- written consent required:

*Print Name*_____________________________ *Signature*______________________________ *Date*_____________________

I hereby give my permission to the school principal and/or ECLC of NJ staff to obtain emergency medication and treatment if required for my child, and I release ECLC of NJ and its employees from all liability in connection therewith.

Parent/Guardian Signature____ **Date**_______________________________

I hereby give permission for my child____ to go on field trips with his/her class at the ECLC of NJ school during the current school year.

Parent/Guardian Signature____ **Date**_______________________________

I hereby give my permission for my child's health information to be disclosed to the appropriate ECLC of NJ employees who have a legitimate health interest in my child.

Parent/Guardian Signature____ **Date**_______________________________

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AUTHORIZATION FOR NON-PRESCRIPTION MEDICATION ADMINISTRATION

I authorize the ECLC school nurse to administer the following over-the-counter medication to my child during school hours. These medications are in stock in the health office and are approved by the school physician. **Parent/guardian will be contacted prior to administration of any medication.**

Please **CHECK** the medications that may be administered at school with parent permission:

_____Acetaminophen (Tylenol) – for headache, pain or fever

_____Ibuprofen (Motrin/Advil) – for headache, pain or fever

_____Benadryl – for allergy symptoms

_____Antibiotic Ointment- apply to skin for first aid/wound care

_____Hydrocortisone Cream 1%- apply to skin for itch or insect bites

_____Calamine Lotion- apply to skin for skin rash or insect bites

All other medications, both prescription and over-the-counter, require a medical order from your student's physician. Medication forms and the medication administration procedure can be found in the health packet.

Student Name ____

Parent Signature ____ Date ___________________________

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